TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
7551 Metro Center Drive, Suite 100, Austin, Texas 78744-1645
(512) 804-4000 | F: (512) 804-4811 | (800) 252-7031 | TDI.texas.gov | @TexasTDI

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ADL SERVICES INC

Respondent Name
TEXAS MUTUAL INSURANCE CO

MFDR Tracking Number
M4-14-1685-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
FEBRUARY 7, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After exhausting our efforts with Texas Mutual Insurance Company, our agency is required to appeal for the attached billing cycles due to being denied."

Amount in Dispute: $2,880.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor provided home health aide services to the claimant on the dates of service above. The requestor initially billed code S5125… Texas Mutual maintains its position that the bills were untimely."

Response Submitted by: Texas Mutual Insurance Company

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 26, 2013 through March 31, 2013	G0156	$2,880.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the requirements for medical bill submission by the health care provider.

3. 28 Texas Administrative Code §102.4 establishes rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out provisions related to payment of health care providers.
5. Texas Labor Code §408.0272 provides for certain exceptions to untimely submission of a medical claim.
6. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 - The time limit for filing has expired
   - 731 – Per 133.20 provider shall not submit a medical bill later than the 95th day after the date the service, for services on or after 09/01/05.
   - W1 – Workers Compensation State Fee Schedule adjustment.
   - 892 = Denied in accordance with DWC Rules and/or medical fee guideline including current CPT Code descriptions/instructions.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 226 – Information requested from the billing/rendering provider was not provided or was insufficient/incomplete.
   - 891 – No additional payment after reconsideration.

Issues

1. Did the requestor submit CMS-1500s and EOBs for disputed dates of service February 28, 2013, March 14, 2013 and March 31, 2013?
2. What is the timely filing deadline applicable to the medical bills for the service dates February 28, 2013, March 14, 2013 and March 31, 2013 in dispute?
3. Did ADL Services forfeit the right to reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.307(c)(2)(J), requires that the request shall include "a paper copy of all medical bill(s) related to the dispute, as originally submitted to the insurance carrier . . . and a paper copy of all medical bill(s) submitted to the insurance carrier for an appeal in accordance with §133.250" Review of the submitted documentation finds that the requestor has not provided a copy of the medical bill(s) as originally submitted to the insurance carrier and/or as submitted to the insurance carrier for an appeal in accordance with §133.250. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(J) for dates of service February 28, 2013, March 14, 2013 and March 31, 2013.

   28 Texas Administrative Code §133.307(c)(2)(K), requires that the request shall include "a paper copy of each explanation of benefits (EOB) related to the dispute as originally submitted to the health care provider . . . or, if no EOB was received, convincing documentation providing evidence of insurance carrier receipt of the request for an EOB" Review of the submitted documentation finds that the request does not include copies of any EOBs for disputed dates of services February 28, 2013, March 14, 2013 and March 31, 2013. Nor has the requestor provided evidence of insurance carrier receipt of the request for an EOB. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(K). As a result, reimbursement cannot be recommended for disputed dates of service February 28, 2013, March 14, 2013 and March 31, 2013.

2. The requestor seeks reimbursement for HCPCS Level II Code G0156. The requestor submitted two sets of CMS-1500s, the first set of CMS-1500s documented that the requestor billed with HCPCS Level II Code S5125. The second set of CMS-1500s documented that the requestor changed the HCPCS Level II code to G0156, the code identified on the *Table of Disputed Services*. The Division will therefore review the EOBS and CMS-1500's for disputed HCPCS Level II Code G0156 , identified as the disputed service.

3. 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." Texas Labor Code §408.0272(b) provides that:

   Notwithstanding Section 408.027, a health care provider who fails to timely submit a claim for payment to the insurance carrier under Section 408.027(a) does not forfeit the provider's right to reimbursement for that claim for payment solely for failure to submit a timely claim if:
   (1) the provider submits proof satisfactory to the commissioner that the provider, within the period prescribed by Section 408.027(a), erroneously filed for reimbursement with:

(A) an insurer that issues a policy of group accident and health insurance under which the injured employee is a covered insured;
(B) a health maintenance organization that issues an evidence of coverage under which the injured employee is a covered enrollee; or
(C) a workers' compensation insurance carrier other than the insurance carrier liable for the payment of benefits under this title; or
(2) the commissioner determines that the failure resulted from a catastrophic event that substantially interfered with the normal business operations of the provider.

4. Texas Labor Code §408.027(a) states that "Failure by the health care provider to timely submit a claim for payment constitutes a forfeiture of the provider's right to reimbursement for that claim for payment." 28 Texas Administrative Code §102.4(h) states that:

   Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on:
   (1) the date received, if sent by fax, personal delivery or electronic transmission or,
   (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday.

5. Review of the submitted information finds insufficient documentation to support that a medical bill was submitted within 95 days from the date the services were provided. Consequently, the requestor has forfeited the right to reimbursement due to untimely submission of the medical bill, pursuant to Texas Labor Code §408.027(a).

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July 27, 2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.